

P. O. Box 1360
Frankfort, KY 40602
(502) 564-3296
<http://slp.ky.gov>



(Name)

(Address)

(City, State, Zip)

SS#:

Date: _____

Amount: \$

☐ Check here if name or address has changed from above. No changes will be made unless marked.

KRS 334A.170 requires each licensed speech-language pathologist assistant to biennially renew his or her license on or before January 31st. Your current license will expire **January 31, 2012**. Failure to renew your license shall constitute sufficient cause for termination of licensure. **Licenses not renewed by March 2, 2012 (includes 30 day grace period) will terminate and you are hereby advised at such time you must CEASE AND DESIST the practice of speech-language pathology and/or audiology in Kentucky.**

- Complete this form by filling in the information requested below. Incomplete forms **will be** returned.
- Attach the appropriate renewal fee: Forms received without the appropriate fee **will be** returned. ***Make check or money order payable to the Kentucky State Treasurer. DO NOT SEND CASH.***

Renewals mailed on or before January 31 - (must be postmarked on or before January 31) – Active \$100.00; Inactive license - \$20.00

Renewals mailed January 31 through March 2 - (must be postmarked on or before March 2) – Active \$150.00; Inactive license - \$20.00

- Complete the backside of this renewal application for continuing education credit. Each speech-language pathologist assistant must list thirty (30) hours of continuing education obtained during this renewal period. The board will require documentation of obtained continuing education hours if you are audited. DO NOT attach documentation of continuing education hours unless you are requested to do so. We cannot accept hours that have not been earned. **You must wait to file your renewal until after all requirements are met.**
- Return this form with your check to the address listed above on or before January 31, 2012 **Any form, which is returned due to incomplete or incorrect information, will be subject to late penalties if not returned by the deadlines stated above.**

Name: _____ Social Security # _____ License #: SLPA _____

Home Address:

Street or Box number	City	State	Zip Code	County
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Present Business Address:

Name of Company	Street or Box number	City	State	Zip Code
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Home Phone: _____ Business Phone: _____ E-Mail: _____

☐ Requesting to change to active status from inactive status. **(Fee required, Continuing education must be listed on back side)**
☐ Remaining on active status. **(Fee required, Continuing Education must be listed on back side)**
☐ First renewal period. **Fee required, Date of initial license:** _____
☐ Currently on an Inactive Status. **(Fee required, No Continuing Education required)**
☐ Requesting an Inactive Status. **(Fee required, No Continuing Education hours required)**
☐ Requesting Termination. **(No fee required, No Continuing Education required)**

The backside of this application MUST be completed. Incomplete applications WILL be returned.

Regardless of whether you are an odd-numbered licensee or even numbered licensee for the renewal period ending January 31, 2010, each licensee shall obtain a minimum of thirty (30) hours of continuing education for the renewal period year. All hours shall be in or related to the specific area in which you are licensed. Only four (4) hours may be "related to" areas each year. Each speech-language pathologist assistant is responsible for securing documentation to support proof of attendance.

List below the hours of continuing education obtained, INCLUDING COMPLETE DATE AND HOURS OBTAINED. Incomplete forms will be returned. (DO NOT attach documentation unless you are audited. It is your responsibility to maintain all documentation.) If using hours carried over from the previous renewal year, you must list the course name, date and number of hours being carried over.

Course Name (Required)	Date(s) M/D/Y (Required)	30 Hours Earned (Required)

Total CE hours earned January 1 to December 31 = _____

Total CE hours earned during current renewal and grace period (January 1 to March 2) = _____

I hereby certify that all information provided by me on this form is true and correct to the best of my knowledge. (Signature is required. Forms not signed will be returned and subject to late penalties if not returned by the deadlines stated.)

Signature: _____ Date: _____

TO BE COMPLETED BY SUPERVISOR: This section must be completed. Incomplete forms will be returned and subject to late penalties if not returned by the deadlines stated. Please check the appropriate box or boxes:

- ☐ I am the original supervisor for this licensee.
- ☐ I am not the original supervisor for this licensee. I began supervising this individual on _____.
(Must complete a Change in Supervision and/or PPE Setting form if one has not been completed and approved by the Board)
- ☐ I recommend that this individual's speech-language pathology assistant license be renewed for the renewal period stated on the front of this application and hereby agree to provide supervision as required by KRS 334.035 (2) and as defined by 201 KAR 17:027 for this licensee to function as a speech-language pathology assistant during the period of this license. I further agree to accept responsibility for the practice and activities of this licensee in his/her capacity as a speech-language pathology assistant. I acknowledge that the failure to utilize this person appropriately as a speech-language pathology assistant and to supervise in accordance with the above cited provisions of Chapter 334A of the Kentucky Revised Statutes and the administrative regulations promulgated thereunder, shall be considered as aiding and abetting an unlicensed person to practice speech-language pathology as described in KRS Chapter 334A.
- ☐ I do not recommend that this individual's speech-language pathology assistant license be renewed for the renewal period state on the front of this application. Please explain on a separate sheet of paper and attach to this renewal application.

Supervisors Signature _____

Date _____

Street Address _____

Phone Number _____

City, State, Zip Code _____

License Number and/or KY Teaching Certificate Number
If you are not the original supervisor & do not hold a KY SLP
License, please attach a copy of your KY Teaching Certificate.

If you are interested in paying your renewal fee electronically, please follow the instructions listed on the Kentucky Board of Speech-Language Pathology and Audiology web site.

<http://slp.ky.gov>